MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09020

CERTIFICATE OF DEATH

09028 355

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY
c. LENGTH OF STAY IN 1b: 70 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY X2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOTTIE Middle M. Last BRADFORD

4. DATE OF DEATH: Month AUG Day 17 Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG. 18, 1877

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): NEWARK MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN SMITH

14. MOTHER'S MAIDEN NAME: AMANDA JACKSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: MD
MR. HARRY A. BRADFORD, OCEAN CITY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
593 x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c): Chr. Brights

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from July 10-, 1957, to Aug 17-, 1957, that I last saw the deceased alive on Aug 17-, 1957, and that death occurred at 3 30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas. R. Law M.D. ADDRESS (Street, city or town, state): Berlin Md. DATE SIGNED: Aug 20-57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/20/57

22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

22d. LOCATION (City, town, or county): BERLIN (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Bunting ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: AUG 22 1957

24b. REGISTRAR'S SIGNATURE: Helen F. Heyward

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09021

CERTIFICATE OF DEATH

09029

Reg. Dist. No. 3rd

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X OCEAN CITY
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle THOMAS Last BURBAGE

4. DATE OF DEATH: Month AUG. Day 6 Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: DEC. 14 1881

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED COAST GUARD

10b. KIND OF BUSINESS OR INDUSTRY: GOVERNMENT

11. BIRTHPLACE (State or foreign country): BERLIN MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES BURBAGE

14. MOTHER'S MAIDEN NAME: FANNY GARDNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): YES (If yes, give war or dates of service): WORLD WAR I

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MR. LUTHER BURBAGE, SALISBURY MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Complete Heart Block — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO (b): Coronary Sclerosis — 2 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from — 19 56, to 6 Aug 19 57 that I last saw the deceased alive on 6 Aug 19 57, and that death occurred at 10:15 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: N. K. Thomas M.D. ADDRESS (Street, city or town, state): Philadelphia & round st DATE SIGNED: 7 Aug 57

PHYSICIAN'S NAME (Type): N. K. THOMAS

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/8/57

22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

22d. LOCATION (City, town, or county) (State): BERLIN MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna M. Burbage ADDRESS: Berlin md

24a. REC'D BY REGISTRAR DATE: AUG 9 1957

24b. REGISTRAR'S SIGNATURE: Helen F. Haywood

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09030

09022

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH
a. COUNTY Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark #1
c. LENGTH OF STAY IN 1b 76 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md — b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Newark #1
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: Celara — Middle: M. — Last: Leherrit

4. DATE OF DEATH: August 14 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 21—1881

9. AGE (In years last birthday) 75 Yrs 9 Mos 25 Ds — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country) Snow Hill Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward I. Maddox

14. MOTHER'S MAIDEN NAME: Mary Causey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT: Mrs. Roy F. Laherrit Address: Snow Hill Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia & Inanition — INTERVAL BETWEEN ONSET AND DEATH: 4 Mos

446X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Malignant Nephrosclerosis — 10 Mos.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 1, 1957 to Aug 14, 1957, that I last saw the deceased alive on Aug 13 1957, and that death occurred at 1:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Butler LaMar M.D.
ADDRESS (Street, city or town, state): 104 Bay St Snow Hill, Md.
DATE SIGNED: 8-15-57
PHYSICIAN'S NAME (Type): ROBERT C. LA MAR, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Aug 16/57 — 22c. NAME OF CEMETERY OR CREMATORY: Balls Methodist — 22d. LOCATION (City, town, or county) Snow Hill (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE: Millard E. Timms — ADDRESS: Snow Hill, Md

24a. REC'D BY REGISTRAR: AUG 19 1957 — 24b. REGISTRAR'S SIGNATURE: Elwyn Cooper

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09023

CERTIFICATE OF DEATH

09031

Reg. Dist. No. 35

1. PLACE OF DEATH
a. COUNTY: WORCESTER. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN Hb: 3 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 BERLIN
d. STREET ADDRESS: 1 BROAD ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First STEPHEN Middle JOSEPH Last DARDEN

4. DATE OF DEATH: Month AUG. Day 29 Year 19 57

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAR. 20, 1896

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): EXPRESS AGENT RET.

10b. KIND OF BUSINESS OR INDUSTRY: FRUITGROWERS EXPRESS

11. BIRTHPLACE (State or foreign country): CLINTON N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY K. DARDEN

14. MOTHER'S MAIDEN NAME: MINNIE KING.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WORLD WAR I

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: MRS. S. S. DARDEN Address: BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic Coma and failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
DUE TO
156.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Malignancy of liver — 2 months
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Thrombosis 3 years ago.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 1956 to August, 1957, that I last saw the deceased alive on August 29, 1957, and that death occurred at 3:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A. Grubb MD M.D. ADDRESS (Street, city or town, state): BERLIN, MD. DATE SIGNED: 8-30-57

PHYSICIAN'S NAME (Type): ROBERT A. GRUBB, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/31/57

22c. NAME OF CEMETERY OR CREMATORY: BUCKINGHAM

22d. LOCATION (City, town, or county) (State): BERLIN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: SEP 4 1957

24b. REGISTRAR'S SIGNATURE: Helen F. Hayward

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09024

CERTIFICATE OF DEATH

09032 355
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Ocean City
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Ocean City X2
d. STREET ADDRESS: Old State Rd. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie — Middle: Cooper — Last: Davis

4. DATE OF DEATH: Month: 8 — Day: 16 — Year: 1957

5. SEX: F. M.

6. COLOR OR RACE: AA

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 17, 1910

9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Bryant

14. MOTHER'S MAIDEN NAME: Rachel ? Bryant

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Mr. James Davis, West Ocean City, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO
(b): Carcinoma of breast — 2 yrs.
DUE TO
(c):

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1957, to 14 Aug, 1957, that I last saw the deceased alive on 14 Aug, 1957, and that death occurred at 9:40 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. R. Thomas M.D. — ADDRESS (Street, city or town, state): Ocean City, Md — DATE SIGNED: 16 Aug 57

PHYSICIAN'S NAME (Type): W. R. Thomas

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-18-1957

22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

22d. LOCATION (City, town, or county) (State): Berlin, Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. F. Stewart Funeral Home, Salisbury, Md

24c. REC'D BY REGISTRAR — DATE: AUG 21 1957

24b. REGISTRAR'S SIGNATURE: Helen L. Haywood

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09025 **CERTIFICATE OF DEATH** 09033

Reg. Dist. No. 353

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Bishop, Md.
c. LENGTH OF STAY IN 1b: 40 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x/ Bishop — Rural
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Charles Middle Edward Last Fassett

4. DATE OF DEATH: Month Aug. Day 1 Year 1957

5. SEX: Male

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1891

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clay Fassett

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: No

17. INFORMANT: James Fassett — Address: Bishop, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardio-vascular Disease — 3 yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 7, 1954 to July 13, 1957, that I last saw the deceased alive on July 17, 1957, and that death occurred at 7:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ivory U. Sully Jr. M.D. — ADDRESS (Street, city or town, state): Berlin Md — DATE SIGNED: 8/2/57

PHYSICIAN'S NAME (Type): Ivory U. Sully Jr. MD — Berlin Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 4, 1957

22c. NAME OF CEMETERY OR CREMATORY: Sarah Dukes

22d. LOCATION (City, town, or county) (State): Bishop, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry W. Watson — ADDRESS: Pocomoke City, Md

24a. REC'D BY REGISTRAR DATE: AUG 6 1957

24b. REGISTRAR'S SIGNATURE: Hilda F. Bryan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09017

CERTIFICATE OF DEATH

09034

Reg. Dist. No. 350

1 PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 401 Linden Ave.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City 4
d. STREET ADDRESS: 401 Linden Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Sophronia Middle F. Last Gillette

4. DATE OF DEATH: Month August Day 28 Year 19 57

5. SEX: F.
6. COLOR OR RACE: C.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 26, 1878
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Lane
14. MOTHER'S MAIDEN NAME: Maria Waters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-05-2096
17. INFORMANT: 401 Linden Ave. Mrs. Estella L. Shade, Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ~~gastric Carcinoma~~ Dehydration & Exhaustion — INTERVAL BETWEEN ONSET AND DEATH: 6 wks
151X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Gastric Carcinoma — 6 mths
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Ca of Colon.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/3/55, 19__, to 8/28/57, 19__, that I last saw the deceased alive on 8/27/57, 19__, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Cecil A. Duverney M.D. ADDRESS (Street, city or town, state): 801 — 4th St, Pocomoke DATE SIGNED: 8/29/57
PHYSICIAN'S NAME (Type): Cecil A. Duverney, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/31/57
22c. NAME OF CEMETERY OR CREMATORY: Halls Hill Cem.
22d. LOCATION (City, town, or county) (State): Pocomoke City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton — ADDRESS: New Church, Va.
24a. REC'D BY REGISTRAR DATE: 9/3/57
24b. REGISTRAR'S SIGNATURE: Anna E. White

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09018

CERTIFICATE OF DEATH

Reg. Dist. No. 09035 398

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Home

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke
d. STREET ADDRESS: 515 Jamel St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First JOHN Middle Last HAYES

4. DATE OF DEATH: Month August Day 31 Year 1957

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 26, 1886

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: mining

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14 MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 233-14-0968

17. INFORMANT Address: Lucy Hayes - 515 Jamel St. Pocomoke Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Exhaustion & Dehydration — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

177x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cancer of Prostate — 4 mths.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ASCVD & Congestive Heart Failure

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/5/57, 19 25, to 8/30/57 19____, that I last saw the deceased alive on 8/30/57, 19____, and that death occurred at____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Cecil A. Duverney M.D. ADDRESS (Street, city or town, state): 801 — 4th St, Pocomoke DATE SIGNED: 8/31/57

PHYSICIAN'S NAME (Type): Cecil A. Duverney, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 4 1957

22c. NAME OF CEMETERY OR CREMATORY: Halls Hill

22d LOCATION (City, town, or county) (State): Pocomoke Md.

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Edgar Wharton - New Church, Va.

24a. REC'D BY REGISTRAR DATE: 9/3/57

24b. REGISTRAR'S SIGNATURE: Anne E. White

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09026 — 09036 — Reg. Dist. No. 395

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL Ocean City
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 34th & Philadelphia Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: BALTIMORE City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE # 15 3 Vol-4
d. STREET ADDRESS: 3820 BARRINGTON Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MRS Elsie — Middle: MARY — Last: Holden

4. DATE OF DEATH: Month: August — Day: 8 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAR 3 1889

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Adam Osterman

14. MOTHER'S MAIDEN NAME: Barbara Boh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MRS. David A. Williams (SISTER) — Address: Broadview Apts Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

DUE TO (b): Arteriosclerotic CVD — 4 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c): 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: F Townsend Jr M.D.

EXAMINER'S NAME (Type): FRANCIS J. TOWNSEND JR

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: August 8, 1957.

22a. BURIAL, CREMATION, REMOVAL (Specify): Entombment

22b. DATE THEREOF: 8/12/1957

22c. NAME OF CEMETERY OR CREMATORY: Lorraine Mausoleum

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ellsworth Armacost
ADDRESS: Ellsworth Armacost-4600 Liberty Hghts. Ave.

24a. REC'D BY REGISTRAR: DATE: AUG 12 1957

24b. REGISTRAR'S SIGNATURE: Helen F. Heywood

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

09927

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09037 391

Item 9 Filmed 19 d-20-57 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Worcester County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN 1b: Two days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Georgia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Macon
d. STREET ADDRESS: DK
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First: Daniel Middle: Last: Mathews

4. DATE OF DEATH Month: Aug Day: 9th Year: 1957

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ DK
8. DATE OF BIRTH: DK
9. AGE (In years last birthday): Approx. 38 yrs.
IF UNDER 1 YEAR Months Days / IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Dont Know
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: No record available
14. MOTHER'S MAIDEN NAME: No record available

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: (?)
17. INFORMANT: Snow Hill Police Dept. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning
INTERVAL BETWEEN ONSET AND DEATH: Few minutes

850X

DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell between boat and shore in deep water
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: N. E. Sartorius M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 8/11/57
EXAMINER'S NAME (Type): N. E. Sartorius

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 11/57
22c. NAME OF CEMETERY OR CREMATORY: County Cemetery
22d. LOCATION (City, town, or county): Snow Hill (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas F. Dennis ADDRESS: Snow Hill
24a. REC'D BY REGISTRAR DATE AUG 15 1957
24b. REGISTRAR'S SIGNATURE: Elwyn Cooper

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral dir[redacted]tor. Page 4 should be forwar[redacted] the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar [redacted] to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9028

CERTIFICATE OF DEATH

Reg. Dist. No. 09038 251

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City Md
c. LENGTH OF STAY IN 1b 2 Mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Delaware b. COUNTY Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frankford R.F.D # 2
d. STREET ADDRESS Delaware
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First SURVUSHA Middle MAY Last McCABE

4. DATE OF DEATH Month Aug Day 17 Year 1957

5. SEX Female
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Aug 23 1878
9. AGE (In years last birthday) 78 yrs
IF UNDER 1 YEAR Months 11 Days 25
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Home Wife
11. BIRTHPLACE (State or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joshua Evans.
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 2
16. SOCIAL SECURITY NO. -
17. INFORMANT Address Vance McCabe Frankford Dela.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH 2 days
420.0
DUE TO (b) Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 5 5 19___ to Aug 19 57 that I last saw the deceased alive on Aug 1 19 57, and that death occurred at 1.35 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE William R Campbell M.D. ADDRESS (Street, city or town, state) Bethany Beach DATE SIGNED Aug 18 1957

PHYSICIAN'S NAME (Type) William R Campbell

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8/20/57
22c. NAME OF CEMETERY OR CREMATORY Roxana M.E.
22d. LOCATION (City, town, or county) (State) Roxana Delaware

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Watson & Gray Frankford Dela
24a. REC'D BY REGISTRAR DATE AUG 26 1957
24b. REGISTRAR'S SIGNATURE Helen T. Haywards

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09019 — 09039 — Reg. Dist. No. 220

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b: 47 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 508 Clarke Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 4 2. Pocomoke City
d. STREET ADDRESS: 508 Clarke Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertie — Middle: Mae — Last: McDaniel

4. DATE OF DEATH: Month: August — Day: 21 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 17, 1885

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: John W. Cutler

14 MOTHER'S MAIDEN NAME: Sarah D. Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr. Linwood McDaniel, Pocomoke, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: few Minutes.

DUE TO (b): Degenerative Heart Disease — 4 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1952, to August 21, 1957, that I last saw the deceased alive on August 21, 1957, and that death occurred at 1:30 a. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles W. Trader, M.D. — ADDRESS (Street, city or town, state): Pocomoke City Md. — DATE SIGNED: 8-22-57

PHYSICIAN'S NAME (Type): Charles W. Trader

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 8-23-57 — 22c. NAME OF CEMETERY OR CREMATORY: Baptist Cemetery — 22d LOCATION (City, town, or county) (State): Pocomoke City, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Henry E. Watson — ADDRESS: Pocomoke, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 26 1957 — 24b REGISTRAR'S SIGNATURE: Anne Hester

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9029

09040 355 Reg. Dist. No.

1

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY
c. LENGTH OF STAY IN 1b: 4YRS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY
d. STREET ADDRESS: DOLPHIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle FREDERICK Last MEYER
4. DATE OF DEATH: Month AUG. Day 2 Year 1957
5. SEX: M
COLOR OR RACE: W
MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
6. DATE OF BIRTH: JULY 1, 1872
9. AGE (In years last birthday): 85 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT (RETIRED)
10b. KIND OF BUSINESS OR INDUSTRY: OWN BUSINESS
11. BIRTHPLACE (State or foreign country): BREMEN, GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John D. Meyer
14. MOTHER'S MAIDEN NAME: Friedericke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 216-03-7230
17. INFORMANT: MRS J.E. MEYER Address: DOLPHIN ST. OCEAN CITY MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Homologous Serum Jaundice — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b): Blood transfusion (?) — 4 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic C-V-renal disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1957 to 2 Aug, 1957, that I last saw the deceased alive on 2 Aug, 1957, and that death occurred at 11:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. E. Thomas M.D. — ADDRESS (Street, city or town, state): Peninsula General, Salisbury, Md — DATE SIGNED: 3 Aug 57
PHYSICIAN'S NAME (Type): H. E. THOMAS

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/6/57
22c. NAME OF CEMETERY OR CREMATORY: LORRAINE CEM.
22d. LOCATION (City, town, or county): BALTIMORE (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Anna B. Burbage — ADDRESS: Berlin Md
24a. REC'D BY REGISTRAR DATE: AUG 6 1957
24b. REGISTRAR'S SIGNATURE: Helen F. Haywood

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

13, 14' 7 only 8/6's 7 GE (6, 22) see app #7 v2, Lamoreaux, com.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09041

9030

CERTIFICATE OF DEATH

Reg. Dist. No. 35F

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD
b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Berlin
d. STREET ADDRESS 1 R.F.D.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First George Middle Ewell Last Parsons
4. DATE OF DEATH Month Aug. Day 30 Year 1957

5 SEX M
6. COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH Mar. 31, 1871
9. AGE (In years last birthday) 86 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11 BIRTHPLACE (State or foreign country) Berlin Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME Marion Parsons
14 MOTHER'S MAIDEN NAME Retta Middleton

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. No
17. INFORMANT Address Mr. Elwood Parsons Berlin Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Nephritis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cancer of Stomach
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 4 1957 to Aug 30 1957 that I last saw the deceased alive on Aug 30 1957, and that death occurred at 4:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Chas R Lane M.D. ADDRESS (Street, city or town, state) Berlin Md DATE SIGNED Aug 31-57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 9/2/57
22c. NAME OF CEMETERY OR CREMATORY Taylorville Cem
22d LOCATION (City, town, or county) Berlin (State) Md

23 FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage ADDRESS Berlin Md
24a REC'D BY REGISTRAR DATE SEP 4 1957
24b REGISTRAR'S SIGNATURE Helen Haywards

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be furnished with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be attached with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09042

9131 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 3N

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City
c. LENGTH OF STAY IN 1b 5 Hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Beach at Dorchester St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 3823 Rexmere Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First John Middle T Last Popp JR
4. DATE OF DEATH Month Aug Day 4 Year 1957
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Feb 14 1912
9. AGE (In years last birthday) 45 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER
10b. KIND OF BUSINESS OR INDUSTRY Newspaper
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Popp.
14. MOTHER'S MAIDEN NAME Carrie Beale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Mildred E Popp (Wife) Address 3823 Rexmere Rd Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary occlusion acute	INSTANT.
DUE TO (b)	Arteriosclerotic C.V.D.	2 years
DUE TO (c)	Diabetes Mellitus	2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE H Townsend Jr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) FRANCIS J. TOWNSEND JR
DATE SIGNED Aug 4, 1957.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-7-57
22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.
22d. LOCATION (City, town, or county) (State) Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage ADDRESS Berlin Md
24a. REC'D BY REGISTRAR DATE AUG 6 19
24b. REGISTRAR'S SIGNATURE Helen F Hayward

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9032

CERTIFICATE OF DEATH

09043

Reg. Dist. No 351

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
c. LENGTH OF STAY IN 1b 3 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 113 Gumly St

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE md
b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Doris Middle Lee Last Shackley

4. DATE OF DEATH Month August Day 31 Year 1957

5. SEX Female
6. COLOR OR RACE Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Jul 19 1954
9. AGE (In years last birthday) 3/4/12
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Salisbury Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Theodore Jenkins Jr
14. MOTHER'S MAIDEN NAME Doretha Virginia Shackley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Doretha Virginia Shackley Snow Hill md 113 Gumly St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor — INTERVAL BETWEEN ONSET AND DEATH 6 mo
DUE TO
237 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1957 to 8/30/57 19____, that I last saw the deceased alive on 8/30/57 19____, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE Paul Cohen M.D. ADDRESS (Street, city or town, state) Snow Hill Md. DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Sept 1/57
22c. NAME OF CEMETERY OR CREMATORY Hatton-Lloyd
22d. LOCATION (City, town, or county) Snow Hill (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Tilley & Timmis ADDRESS Snow Hill Md
24a. REC'D BY REGISTRAR DATE SEP 3 1957
24b. REGISTRAR'S SIGNATURE Elwyn Coopers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M II/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11308

9033

Reg. Dist. No. 305

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY Worcester Co — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin — LENGTH OF STAY (in this place) Life

HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md — COUNTY Worcester

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin

STREET ADDRESS (If rural give location) R.F.D. #2

3. NAME OF DECEASED (Type or Print) — (First) George — (Middle) Ed — (Last) Timmons

4. DATE OF DEATH — (Month) 8 — (Day) 25 — (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
M	Col	Married	12-18-1867	89 yrs.	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Worcester Co

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Sylvus Timmons

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS Mary Timmons

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

22.2 IMMEDIATE CAUSE (A) Degenerative Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 15 mos

ANTECEDENT CAUSE(S) DUE TO (B) Senility

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/9, 1956, to 8/7, 1957, that I last saw the deceased alive on 8/7, 1957, and that death occurred at 4:30 P M, from the causes and on the date stated above.

SIGNATURE Irving A. Lucy M.D. — ADDRESS (Street, city, town, state) Berlin, Md — DATE SIGNED 8/26/57

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-29-57	Evergreen Cem	Berlin Md

24. REC'D BY REGISTRAR — DATE OCT 16 1957 — REGISTRAR'S SIGNATURE Helen F. Fitzgerald

25. FUNERAL DIRECTOR'S SIGNATURE Booker Hall — ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09044 355

9034 **CERTIFICATE OF DEATH** Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whaleyville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: XXX

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Whaleyville
d. STREET ADDRESS: 1 XXX
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle Edward — Last Tingle

4. DATE OF DEATH: Month Aug. — Day 16 — Year 1957

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 16, 1880

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Auto

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Tingle

14. MOTHER'S MAIDEN NAME: Angeline Brevard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 910-219-03-6771

17. INFORMANT: Jennie Tingle — Address: WhaleyvilleMd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
002X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Congestive Heart Failure — 2 days
DUE TO
(c): Chronic Pulmonary Tuberculosis — 1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/24, 19 56, to 8/15, 19 57, that I last saw the deceased alive on 8-15, 19 57, and that death occurred at 8:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ivory U. Scully, Jr. M.D. — ADDRESS (Street, city or town, state): Berlin, Md — DATE SIGNED: 8/16/57

PHYSICIAN'S NAME (Type): Ivory U. Scully, Jr. MD Berlin, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-18-57

22c. NAME OF CEMETERY OR CREMATORY: Pulletts Chapel

22d. LOCATION (City, town, or county) (State): Whaleyville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley — ADDRESS: Selbyville, Del.

24a. REC'D BY REGISTRAR DATE: AUG 20 1957

24b. REGISTRAR'S SIGNATURE: Helen Haywards

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9035 — 09045 — Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b: 2 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD.
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WLADIMIR Middle Last WACYK
4. DATE OF DEATH: Month August Day 18, Year 1957 3:20 P.M.
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 1907
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): VETINARY
10b. KIND OF BUSINESS OR INDUSTRY: POULTRY
11. BIRTHPLACE (State or foreign country): TARNOPOL, POLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JAKAB WACYK
14. MOTHER'S MAIDEN NAME: JOSEFA FEDOROWYCH
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: DR. DONALD NOLL, BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 20 min
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. —
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) (County) (State) —

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑ Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Herman A. Robbins M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: Aug 20, 1957
EXAMINER'S NAME (Type): HERMAN A. ROBBINS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/26/57
22c. NAME OF CEMETERY OR CREMATORY: SOUTH HILL
22d. LOCATION (City, town, or county) (State): PRINCE ALBERT, CANADA
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Anne A. Burbage Berlin Md
24a. REC'D BY REGISTRAR DATE: AUG 22 1957
24b. REGISTRAR'S SIGNATURE: Helen L. Hayward

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain. Page 4 should be executed, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

VS. A15ME(5)
5M 9/55